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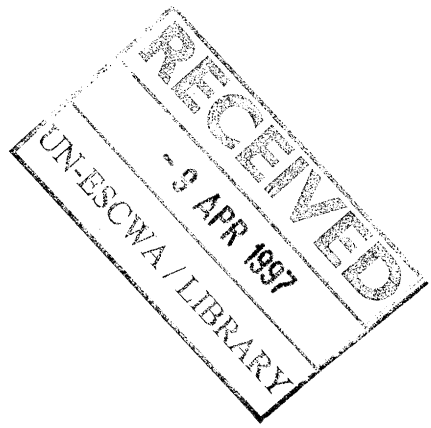

THE REALISTIC APPROACH OF THE WORLD HEALTH ORGANIZATION TO DISABILITY PREVENTION AND MANAGEMENT THROUGH COMMUNITY-BASED REHABILITATION

1. Overview of the problems related to disability and rehabilitation and approaches of the World Health Organization (WHO)

1.1 Number of disabled and number of people needing rehabilitation

Several large-scale surveys from industrialized countries indicate a disability rate affecting about 10 per cent of the population. In developing countries, some 100 studies (surveys, censuses, etc.) have been made. Comparing the outcome of these studies is difficult because different methods have been used. It would, however, be reasonable to assume that 5 to 7 per cent of the population in developing countries – or some 220 million people – are disabled. The largest group of disabled persons is made up of those with mobility difficulties (caused by poliomyelitis, cerebral palsy, muscle diseases, etc.). Next follow hearing/deafness and sight/blindness problems. Mental retardation and mental illness are curently less serious problems.

Based on field experience, it is estimated that about half the disabled in these countries, or about 100 million people, could benefit from rehabilitation. The number is increasing; by the year 2000 it is expected to include some 130-150 million persons. Only about 2-3 million currently receive rehabilitation treatment. This means that 97-98 per cent of all the disabled who could benefit from rehabilitation have no access to such services.

1.2 The WHO approach: community-based rehabilitation (CBR)

The large gap between the services needed and those provided presents a dilemma. Many years ago it was common to think that if one had just a little patience, one would be able to train rehabilitation professionals, build facilities for rehabilitation centres and "catch up" with the problem using the institution-based approach. It took some time to realize that this would not be possible for the following reasons.

- Developing countries are now, and will be for a long period in the future, short of trained rehabilitation manpower.

- Building, equipping and maintaining facilities and staff is very costly, especially if one uses teams of professionals.

- The population is growing at a very high rate in developing countries.

- When the exceedingly high death rate among children with disabilities is reduced, more children and adults with disabilities will survive, thus increasing the prevalence of disability.

In some countries it would take more than 100 years to "catch up" using institution based or outreach service approaches.

WHO has advocated an innovative solution to this dilemma: the so-called community-based rehabilitation. This implies a large scale transfer of knowledge about disabilities and skills in rehabilitation to people with disabilities, to their families, and to community members. Such a decentralized approach brings services to people who cannot afford to leave their communities. More importantly, it provides services where rehabilitation ultimately takes place - in the home and the community.

All needs cannot be met with services at the community level. However, as much as 70 per cent of needs could be dealt with in the community. This would be a major achievement compared with the 2-3 per cent of the needs which are now met in many countries. The remaining needs must be met through referrals to district, provincial and national levels. There should be adequate professional staff at those levels to deal with the problems which cannot be solved in the community.

WHO has produced a manual, "Training in the community for people with disabilities", which discusses in detail (700 pages) the procedures for rehabilitation in the family and the community. Family members train their disabled adults and children at home, using the same basic principles used by professionals.

The results are of excellent quality. About 85 per cent of all disabled persons will become independent, or greatly improve their ability in daily life activities, communication and mobility. This also means that disabled children can be integrated into local schools and, later on, as adults, into jobs. A scientific evaluation of the outcome of community-based rehabilitation was undertaken during the last year by external evaluators in the Philippines and Zimbabwe.

WHO strongly advocates that all countries should develop CBR as a priority and, for those who are interested in doing so, WHO can offer documentation and technical support.

1.3 New ideas related to orthopaedic workshops

Another areas of interest relates to orthopaedic workshops. WHO has recently started to promote a new concept: "the orthopaedic workshop without machines".

The "classical" orthopaedic workshop is mostly a large building full of machines for producing wood, metal and leather components of prostheses. Because of the high cost of such workshops and the requirements for highly trained personnel, these workshops are almost exclusively in large cities.

During the last decades there has been a trend in orthopaedic technology towards the use of more modern materials, namely thermoplastics, such as polyvinyl chloride (PVC), polypropylene and polyethene. Almost all components of prostheses can now be made of such materials. The manufacturing procedures are simple; only an oven and some tools are required. This means that such workshops can be set up at district level; each will only cost $US 5,000 - 10,000.

If this new idea can be implemented, workshops will be more accessible to those who need them, costs will be much lower and the products will be of better quality.

2. The major issues within the ESCWA region

Disability is more common in this region than in any other part of the world, because of war, hostilities and civil unrest in a large number of countries. This has caused an increase in the number of people with amputations, paraplegia, injuries causing mobility problems, brain damage and blindness. Thus rehabilitation services must be augmented in order to provide rapidly what is needed.

Another problem relates to the co-ordination of rehabilitation services. Many ministries, agencies and non-governmental organizations (NGOs) are involved, and at present co-ordination is for the most part inadequate.

3. Policies and measures in effect and those required to deal with the situation in the countries of the region

WHO policies are generally focused on achieving "Health for all by the year 2000". The primary health care approach is given priority in the organization's policies as well as in its responses to requests for funding.

Rehabilitation is seen as a component of primary health care, but so far only a few countries in the region have included it. It is hoped that more attention will be paid to the disabled population as primary health care develops.

4. The role of WHO in substantive or funding assistance to the Governments and NGOs

WHO has a Medium-Term Programme (MTP) which contains programme objectives and activities both on a global and on a regional basis. This MTP is discussed and approved by WHO member States. Both global and regional funds are allocated to countries after a thorough analysis of the needs of each country. Among these needs; rehabilitation of the disabled is an important area for consideration and collaboration.

WHO does not support NGOs. In the area of rehabilitation, a large number of NGOs now support the setting up of CBR programmes, most often in direct co-operation with WHO. However, the total regular budgetary funds allocated for rehabilitation activities in 12 out of the 23 eastern Mediterranean regional countries for 1988/1989 equals $US 906,600. In addition, $US 18,000 are allocated from the regular budget to inter-country activities and about $US 600,000 are deposited as funds in trust to cover costs of WHO collaboration in rehabilitation in a 13th country. The 13 countries are Afghanistan, Egypt, Iran, Iraq, Jordan, Lebanon, Morocco, Pakistan, Saudi Arabia, Somalia, the Sudan, the Syrian Arab Republic and Yemen.